Bureau of Health Care Quality and Compliance

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NVS4767HIC		A. BUILDING B. WING		1	C 03/10/2011	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		-	
WILLIAMS	PERSONAL HOME CAR	RE		AMPO GRAND AS, NV 8908				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
H 000	Initial Comments			H 000				
	a result of a State Lic your facility on 2/15/1 survey was conducted Homes for Individual by the State Board of 1999. The findings and conducted by the Health Division prohibiting any crimin actions or other claim available to any party	ficiencies was generate ensure survey conduct 1. This State Licensure d by authority of NAC 4 Residential Care, adop Health on November 2 clusions of any investign shall not be construed al or civil investigations s for relief that may be under applicable feder	ted in e 49, ted 9, ation l as					
	available to any party under applicable federal, state or local laws. The census at the time of the survey was two. Two resident files were reviewed and two employee files were reviewed. The following regulatory deficiencies were identified:		D .					
H 019	Director Duties-No FA	VCPR		H 019				
	The director of a hom 4. Ensure that a care meeting the needs of trained in first aid, and	giver, who is capable of the residents and has led cardiopulmonary e premises of the home	; been					
	Based on record reviewdid not ensure 1 of 2	ot met as evidenced by: ew on 2/15/11, the direct caregivers had current onary resuscitation (CF	ctor					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB					(X3) DATE SURVEY COMPLETED		
				A. BUILDING B. WING			;	
		NVS4767HIC				03/1	0/2011	
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA				
WILLIAMS	PERSONAL HOME CAP	RE		3404 EL CAMPO GRANDE AVE N LAS VEGAS, NV 89084				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
H 019	Continued From page	e 1		H 019				
	and first aid (Employee #1).							
H 040	Agreement Concerning	ng Rates		H 040				
	NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents. (NRS 449.249) The operator of a home shall: 1. Enter into a written agreement with each resident of the home that sets forth the basic rate for the services of the home and the charges for any optional services.		: rate					
	This Regulation is no	ot met as evidenced by:						
H 043	Records of Residents	s-Address Family&Phys	ician	H 043				
	Records of Residents-Address Family&Physicial NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents. (NRS 449.249) The operator of a home shall: 2. Maintain a separate, organized file for each resident of the home and retain the file for 5 years after the resident permanently leaves the home. Each file must include: (b) The address and telephone number of the resident's physician and a person who is responsible for the resident.		ch the					
	Based on record revie	ot met as evidenced by: ew on 2/15/11, the facil ident files did contained	ity did					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l` ′	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
				A. BUILDING B. WING		с	
		NVS4767HIC				03/	10/2011
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
WILLIAMS	S PERSONAL HOME CAR	RE		AMPO GRAND SAS, NV 89084			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
H 043	Continued From page 2			H 043			
	address and telephone number of a person who is responsible for the resident (Resident #1).						
H 050	Tuberculosis-Employees			H 050			
	dependent and home care: Management of cases; surveillance at counseling and preve 1. A case having tube considered to have tu facility or a facility for managed in accordar Centers for Disease (adopted by reference subsection 1 of NAC 2. A medical facility, a a home for individual maintain surveillance or home for tuberculo infection. The surveill conducted in accordare commendations of Control and Preventic transmission of tuberchealth care set forth in Centers for Disease (adopted by reference subsection 1 of NAC 3. Before initial emploin a medical facility, a	erculosis or suspected of aberculosis in a medical the dependent must be accepted and prevention in paragraph (h) of 441A.200. A facility for the dependence with the guidelines of employees of the facts and tuberculosis ance of employees must be control and Prevention the Guidelines of the coulosis in facilities proving the guidelines of the Control and Prevention in paragraph (h) of 441A.200. Syment, a person employee and the dependence of	tial case case cof the cas ent or cility st be coding cas coyed cont or				
	a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious		te of and				
	stage; and (b) Tuberculosis scre						

AND DIAM OF CODDECTION		(X1) PROVIDER/SUPPLIER/C		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
		NVS4767HIC		B. WING		03/10	0/2011
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
WILLIAMS	S PERSONAL HOME CAR	RE	3404 EL CAN N LAS VEGA				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
H 050	history of bacillus Cal vaccination. If the employee has of of a 2-step Mantoux to preceding 12 months 2-step Mantoux tuber single-step tuberculos administered. A single screening test must be unless the medical did designee or another I determines that the riappropriate for a less documents that deter exposure and correspexamination must be guidelines of the Cen Prevention as adopte (h) of subsection 1 of 4. An employee with a positive tuberculosis of strom screening with some suggestive of tubercutosis screening to subsection 3 shall and medical evaluation 6. Counseling and preoffered to a person we screening test in according of subsection 1 of 7. A medical facility strongless for the design of the desi	including persons with mette-Guerin (BCG) anly completed the first uberculin skin test within then the second step oculin skin test or other sis screening test must be annual tuberculosis and administered thereafted to of the facility or hidensed physician sk of exposure is per frequency of testing mination. The risk of conding frequency of determined by following ters for Disease Control of the properties of the properti	step in the of the be ter, nis and g the ol and graph of a ot suant graph is. t be sis nes graph ce of	H 050	DEFICIENCY)		
	or a positive tuberculo	osis screening test shall infection control specia	ı				

	NT OF DEFICIENCIES NOF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS4767HIC		B. WING		03/1	C 0/2011
NAME OF PE	ROVIDER OR SUPPLIER	NVO II OTTIIG	STREET ADD	RESS, CITY, STA	ATE. ZIP CODE		0/2011
	S PERSONAL HOME CAR	RE	3404 EL C	AMPO GRAND AS, NV 89084	DE AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
H 050	Continued From page 4			H 050			
	if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on 2/15/11, the facility failed to ensure 2 of 2 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing (Employee #1 - an annual one-step TB						
	test and Employee #2 skin test).	2 - missing a two-step T	В				
H 055	NAC 441A.380 Admis medical facilities, faci homes for individual r respiratory isolation; recounseling and preve documentation. (NRS 1. Except as otherwis before admitting a pe extended care, skilled care, the staff of the f chest radiograph of the within 30 days preced 2. Except as otherwis the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of a facility for individual residential of the staff of the staff of a facility for individual residential of the staff of the staff of the staff of the staff of a facility for individual residential of the staff o	ssion of persons to cert lities for the dependent residential care: Testing medical treatment; entive treatment;	or g; on, y for ee a en ucility. on, ne for y for	H 055			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUF COMPLETE	ED
		NVS4767HIC		B. WING		_) 0/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRES	SS, CITY, STA	ATE, ZIP CODE		
WILLIAMS	PERSONAL HOME CAF	RE	3404 EL CAM N LAS VEGAS				
	0.19.49.57.07	ATEMENT OF RESIDENCIES				<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
H 055	Continued From page			H 055			
	home, determine if the (1) Has had a cough of (2) Has a cough which (3) Has blood in his sign (4) Has a fever which cold, flu or other apparation (5) Is experiencing unit (6) Is experiencing unit (7) Has been in close has active tuberculosit (b) Within 24 hours af person with a history (BCG) vaccination, is home, ensure that the screening test, unless qualified to administer a person qualified to a facility or home when staff of the facility or hest is performed with person arrives at the staff (2) Has bloom (2) Has bloom (3) Has bloom (4) Has bloom (5) Has bloom (6) Has bloom (7) Has bloom (7) Has bloom (7) Has bloom (8) Has a fever which a series in the staff of the facility or hest is performed with person arrives at the staff (8) Has a fever which (8) Ha	for more than 3 weeks; h is productive; putum; is not associated with a rent illness; ght sweats; explained weight loss; contact with a person vis. Iter a person, including of bacillus Calmette-Guadmitted to the facility experson has a tubercul a there is not a person or the test in the facility of the test in the facility of the person is admitted to the facility of the test in the facility of the test in the facility of the person is admitted forms shall ensure that in 24 hours after a qualfacility or home or within	or who a uerin or osis or s not e , the the lified n 5				
	days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has		step thin				
			as				
	facility or home shall e a single tuberculosis s thereafter, unless the	osis screening test, the ensure that the person screening test annually medical director or his	has				
	designee or another li determines that the ris appropriate for a lesse documents that deter exposure and corresp	sk of exposure is er frequency of testing mination. The risk of	and				

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/C		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		NVS4767HIC				03/10/	2011
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
WILLIAMS	S PERSONAL HOME CAR	RE	3404 EL CAN N LAS VEGA				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
H 055	guidelines as adopted (h) of subsection 1 of 3. A person with a dopositive tuberculosis of from skin testing and radiographs, but the shall ensure that the pannually for the presesymptoms of tubercul 4. If the staff of the farthat a person has had weeks and that he has symptoms described subsection 2, the person facility or home if the respiratory isolation in guidelines of the Center Prevention as adopte (h) of subsection 1 of health care provider determined to have active tuberd to have active tuberd 5. If a test or evaluation has suspected or active the facility or home of admitted, shall not alluthe facility or home, unkeeps the person in reperson must be kept in health care provider of does not have active although the person in no longer infectious. A not certify that a person to certify that a person with a person certify that a person with a person with a person certify that a person with a person with a person certify that a person with a person with a person certify that a person with a person with a person certify that a person with a pers	determined by following by reference in paragraph NAC 441A.200. Cumented history of a screening test is exemproutine annual chest staff of the facility or horeore or absence of cois. Cility or home determined a cough for more than sone or more of the otin paragraph (a) of son may be admitted to staff keeps the person a accordance with the ters for Disease Control of by reference in paragraph (a) of son may be admitted to staff keeps the person a accordance with the ters for Disease Control of by reference in paragraph (a) the termines whether the erculosis. If the staff is on in respiratory isolation in the person until a henes that the person documents in the person do	g the raph ot me east es a 3 her in the in old and graph not on, salth es in	H 055			

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/G		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		NVS4767HIC				03/10	/2011
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRE				
WILLIAMS	PERSONAL HOME CAR	RE	3404 EL CAN N LAS VEGA				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
H 055	sputum AFIB smears separate days. 6. If a test indicates the or will be admitted to a tuberculosis, the staff ensure that the perso in accordance with the Centers for Disease Counce the counseling of, and person having active recommendations are of the Centers for Disease Of The Centers for	in three consecutive neg which were collected of that a person who has be a facility or home has a of the facility or home in is treated for the dise e recommendations of Control and Prevention of effective treatment for tuberculosis. The e set forth in the guideling ease Control and do by reference in parage NAC 441A.200. Which is the guideling ease Control and do by reference in parage NAC 441A.200. Which is the guideling ease Control and do by reference in parage NAC 441A.200. Which is the guideling ease Control and do by reference in parage of the string accordance with the control of the string dout pursuant to this set of are documented in the cord.	gative on een active shall asse the for r, a nes graph re e th antrol 200. re ection e	H 055			
	Based on record revie	- missing an annual	ity				

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
	IDENTI TOATTON NOMBER.			A. BUILDING B. WING			
		NVS4767HIC				03/1	0/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
WILLIAMS	PERSONAL HOME CAF	RE		AMPO GRAND AS, NV 8908			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
H 060	Ultimate User Agreement			H 060			
	NRS 453.375 Authority to possess and administer controlled substances. A controlled substance may be possessed and administered by the following persons:						
	6. An ultimate user or any person whom the ultimate user designates pursuant to a written agreement.						
	NRS 454.213 Authority to possess and administer dangerous drug. [Effective through December 31, 2007.] A drug or medicine referred to in NRS 454.181 to 454.371, inclusive, may be possessed and administered by:						
	10. An ultimate user or any person designated by the ultimate user pursuant to a written agreement.		ed by				
	Based on record revie not obtain a signed ul	ot met as evidenced by: ew on 2/15/11, the facil ltimate user agreement of to administer medicati esident #1).	ity did				
H 065	Employee Backgroun	d Check Requirements	;	H 065			
	criminal history of em	nd periodic investigatio ployee or independent agency, facility or home					

NVS4767HIC B. WING 03/10/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			NVS4767HIC		B. WING			2011
	NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE	•	
WILLIAMS PERSONAL HOME CARE 3404 EL CAMPO GRANDE AVE N LAS VEGAS, NV 89084	WILLIAMS	S PERSONAL HOME CAF	RE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
1. Except as otherwise provided in subsection 2, within 10 days after hiring an employee or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing, a residential facility for groups or a home for individual residential care shall: (a) Obtain a written statement from the employee or independent contractor stating whether he or she has been convicted of any crime listed in NRS 449.188. (b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a); (c) Obtain from the employee or independent contractor two sets of fingerprints to the Central Repository for Nevada Records of Criminal History for Submission to the Federal Bureau of Investigation for its report; and (d) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (c). 2. The administrator of, or the person licensed to operate, an agency to provide nursing in the home, an agency to provide nursing an excitant the information described in subsection of his or her criminal history thas been conducted by	H 065	1. Except as otherwis within 10 days after hentering into a contractor, the adminilicensed to operate, a personal care service provide nursing in the intermediate care, a fresidential facility for gindividual residential (a) Obtain a written stor independent contrashe has been convict NRS 449.188. (b) Obtain an oral and information contained obtained pursuant to (c) Obtain from the ercontractor two sets of authorization to forwal Central Repository for Criminal History for su Bureau of Investigation (d) Submit to the Central Repository for Criminal History for su Bureau of Investigation (d) Submit to the Central Repository for Surial Probatined pursuant to 2. The administrator coperate, an agency to services in the home, nursing in the home, care, a facility for groups or a residential care is not information described employee or independent of the provides proof that arcriminal history has becentral Repository for the surial repository for the contral Repository for the surial repository for the contral Repository for the surial repository for the contral Repository for the contral Repository for the surial repository for the contral	se provided in subsection iring an employee or control with an independent istrator of, or the person agency to provide as in the home, an agency to skilled nursing groups or a home for care shall: tatement from the employer of any crime listed in the written confirmation of any crime listed in the written statement paragraph (a); and the fingerprints and a written are the fingerprints to the report; and attral Repository for New distory the fingerprints paragraph (c). Of, or the person license of provide personal care an agency to provide a facility for intermediated nursing, a residential the fingerprint obtain the lin subsection 1 from a dent contractor who in eventing the required to obtain the required to obtain the lin subsection 1 from a dent contractor who in eventing the records of the reco	on 2, n acy to g, a oyee e or n f the nt den e al ada ed to de al in her	H 065			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR COMPLETE	ED
		NVS4767HIC		B. WING		_	/2011
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	•	
WILLIAMS	S PERSONAL HOME CAR	RE	3404 EL CAM N LAS VEGAS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
H 065	been convicted of any 449.188. 3. The administrator of operate, an agency to services in the home, nursing in the home, a care, a facility for skill facility for groups or a residential care shall history of each emplo contractor who works investigated at least of administrator or perso (a) If the agency, facil the fingerprints of the contractor on file, obtain the employee or (b) Obtain written autiemployee or independent the fingerprints on file paragraph (a) to the Contractor of the contractor of contractor of the contractor of the contractor on file, obtain written autiemployee or independent the fingerprints on file paragraph (a) to the Contractor of the contractor of the contractor of the fingerprints on the fed of the contractor of the formal contractor of the contractor of the fingerprints on the fed of the contractor o	of, or the person license of provide personal care an agency to provide a facility for intermediated nursing, a residential home for individual ensure that the criminal yee or independent at the agency or facility once every 5 years. The on shall: ity or home does not have employee or independent independent contractor for the dent contractor for the dent contractor to forward or obtained pursuant to central Repository for independent of Investigation of the dent Bureau of Investigation of the dent of the dent of the den	ed to ed to e all y is e ent ents r; ard	H 065	BEHOLINOTY		
	to this section, the Ce Records of Criminal I- whether the employed has been convicted of 449.188 and immedia Division and the admi licensed to operate, that which the person wor independent contra- such a crime.	gerprints submitted pursentral Repository for Netlistory shall determine or independent contral a crime listed in NRS ately inform the Health inistrator of, or the person agency, facility or howorks whether the emplactor has been convicted itory for Nevada Recontral Reconsistory for Nevada Reconsistory or Nevada Reconsistory for Nevada Reco	on ome oyee ed of				

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER						(X3) DATE SURVEY COMPLETED			
	NVS4767HIC			B. WING			C 10/2011		
NAME OF PE	OVIDER OR SUPPLIER	NV34707FIIC	STREET ADD	I RESS, CITY, STA	ATE, ZIP CODE	03/	10/2011		
	S PERSONAL HOME CAF	RE	3404 EL CA	EL CAMPO GRANDE AVE IS VEGAS, NV 89084					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
H 065	Criminal History may agency, a facility or a fingerprints pursuant reasonable cost of the facility or home may ror independent contra of the fee imposed by the agency, facility or	impose a fee upon an home that submits to this section for the e investigation. The agreeover from the employactor not more than one the Central Repository home requires the dent contractor to pay for posed by the Central ow the employee or or to pay the amount	yee e-half /. If	H 065					
	This Regulation is not met as evidenced by: Based on record review on 2/15/11, the facility not ensure 1 of 2 employees complied with background check requirements per NRS 449.176 (Employee #2 - missing a signed criminal history statement).								

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.